INFERTILITY

Unless such item has a dollar or percentage amount associated with it on the Schedule of Benefits, services, supplies or drugs related to any treatment for infertility including but not limited to: fertility drugs; gynecological or urological procedures the purpose of which is primarily to treat infertility; artificial insemination; in-vitro fertilization; reversal of sterilization procedures and surrogate parenting.

INPATIENT DIAGNOSTIC AND EVALUATIVE PROCEDURES

Inpatient care and related Physician Services rendered in conjunction with an Admission, which is principally for diagnostic studies or evaluative procedures that could have been performed on an outpatient basis are not covered unless the Member's medical condition alone required Admission.

INJURY OR ILLNESS RESULTING FROM CRIMINAL ACTIVITY

Illness contracted or injury sustained as a result of participating in a riot or insurrection, or while engaged in the commission of a felony or an illegal occupation.

INVESTIGATIONAL OR EXPERIMENTAL SERVICES

Services, supplies or drugs that are Investigational or Experimental.

LIFESTYLE IMPROVEMENT SERVICES

Services or supplies relating to lifestyle improvements including, but not limited to, nutrition counseling or physical fitness programs.

MASSAGE THERAPY

Unless such item has a percentage or dollar amount associated with it on the Schedule of Benefits, massage therapy treatment or services.

MEMBERSHIP DUES AND OTHER FEES

Amounts payable (whether in the form of initiation fees, annual dues or otherwise) for membership or use of any gym, workout center, fitness center, club, golf course, wellness center, health club, weight control organization or other similar entity or amounts payable to a trainer of any type.

MISSED PROVIDER APPOINTMENTS

Charges for a Member's appointment with a Provider that the Member did not attend.

NO LEGAL OBLIGATION TO PAY

Any service, supply or charge the Member is not legally obligated to pay.

NOT MEDICALLY NECESSARY SERVICES OR SUPPLIES

Any service or supply that is not Medically Necessary. However, if a service is determined to be not Medically Necessary because it was not rendered in the least costly setting, Covered Expenses will be paid in an amount equal to the amount payable had the service been rendered in the least costly setting.

OBESITY RELATED PROCEDURES

1. Unless such item has a dollar or percentage amount associated with it on the Schedule of Benefits, any Medical Supply or service rendered to a Member for the treatment of obesity or for the purpose of weight reduction. This includes all procedures designed to restrict the Member's ability to assimilate food, such as: gastric by-pass, the insertion of gastric bubbles, the wiring shut of the mouth, and any other procedure the purpose of which is to restrict the ability of a Member to take in food, digest food or assimilate nutrients.

2. Services, supplies or charges for the treatment or correction of complications arising from weight control procedures, services, supplies or charges, such as procedures to reverse these restrictive or diversionary procedures and such reconstructive procedures as may be necessitated by the weight loss produced by these non-covered restrictive or diversionary procedures. Examples of such reconstructive procedures include, but are not limited to, abdominal panniculectomy and removal of excessive skin from arms, legs or other areas of the body.

3. Membership fees to weight control programs.

ORTHOGNATHIC SURGERY

Unless such item has a dollar or percentage amount associated with it on the Schedule of Benefits, any service related to the treatment of malpositions or deformities of the jaw bone(s), dysfunction of the muscles of mastication, or orthognathic deformities.

OUTPATIENT SERVICES THAT ARE NOT PRE-AUTHORIZED

If Pre-Authorization is not received, for an otherwise Covered Expense related to an outpatient service, Benefits will be reduced (up to and including denial) of the Allowable Charge. Outpatient Services requiring Pre-Authorization are listed on the Schedule of Benefits.

OVER-THE-COUNTER DRUGS

Drugs that are available on an over-the-counter basis or otherwise available without a prescription.

PAIN MANAGEMENT PROGRAMS

Chronic pain management programs or multi-disciplinary pain management programs unless Medically Necessary.

PHYSICAL THERAPY ADMISSIONS

All Admissions for physical therapy, except as provided in Article III for rehabilitation Benefits.

PHYSICIAN CHARGES

Charges by a Physician for blood and blood derivatives and for charges for Prescription Drugs or Specialty Drugs that are not consumed at the Physician's office.

PRE-EXISTING CONDITIONS

Charges for services or supplies relating to the treatment of a Pre-Existing Condition during the Pre-Existing Condition Waiting Period.

PRE-MARITAL AND PRE-EMPLOYMENT EXAMINATIONS

Charges for services, supplies or fees for pre-marital or pre-employment examinations.

PRE-OPERATIVE ANESTHESIA CONSULTATION

Charges for pre-operative anesthesia consultation.

PRESCRIPTION DRUG EXCLUSIONS

- Prescription Drugs that have not been prescribed by a Physician.
- Any vitamins except for prenatal vitamins.
- Prescription Drugs not approved by the Food and Drug Administration.
- Prescription Drugs for non-covered therapies, services, or conditions.
- Prescription Drug refills in excess of the number specified on the Physician's prescription order or Prescription Drug refills dispensed more than one (1) year after the original prescription date;
- Unless different time frames are specifically listed on the Schedule of Benefits, more than a thirty-one (31) day supply for Prescription Drugs (ninety (90) day supply for Prescription Drugs obtained through a Mail Service Pharmacy);
- Any type of service or handling fee for Prescription Drugs, including fees for the administration or injection of a Prescription Drug;
- Dosages that exceed the recommended daily dosage of any Prescription Drug as described in the current Physician's Desk Reference or as recommended under the guidelines of the Pharmacy Benefit Manager, whichever is lower;
- Prescription Drugs used for or related to cosmetic purposes, including hair growth, unless otherwise specified on the Schedule of Benefits;
- Prescription Drugs related to any treatment for infertility or impotence including but not limited to, fertility drugs;
- Prescription Drugs administered or dispensed in a Physician's office, Skilled Nursing Facility, Hospital or any other place that is not a Pharmacy licensed to dispense Prescription Drugs in the state where it is operated;
- Prescription Drugs for which there is an over-the-counter equivalent and over-the-counter supplies or supplements;
- Prescription Drugs that are being prescribed for a specific medical condition that are not approved by the Food and Drug Administration for treatment of that condition (except for Prescription Drugs for a specific medical condition that has at least two (2) formal clinical studies or Prescription Drugs for the treatment of a specific type of cancer, provided the drug is recognized for treatment of that specific cancer in at least one standard reference compendia or is found to be safe and effective in formal clinical studies, the results of which have been published in peer reviewed professional medical journals);

- Prescription Drugs that are not consistent with the diagnosis and treatment of a Member's illness, injury or condition, or are excessive in terms of the scope, duration, dosage or intensity of drug therapy that is needed to provide safe, adequate and appropriate care;

- Prescription Drugs or services that require Pre-Authorization by the Corporation and Pre-Authorization is not obtained;

- Prescription Drugs for injury or disease that are paid by worker's compensation benefits (if a worker's compensation claim is settled, it will be considered paid by worker's compensation benefits);

- Prescription Drugs that are not Medically Necessary;

- Prescription Drugs for obesity or weight control, contraceptives or smoking cessation, unless a dollar or percentage amount is included on the Schedule of Benefits with respect to such Prescription Drugs;

- Prescription Drugs used for cosmetic purposes;

- Prescription Drugs that are Specialty Drugs, except as specified on the Schedule of Benefits.

PSYCHOLOGICAL AND EDUCATIONAL TESTING

Psychological or educational diagnostic testing to determine job or occupational placement, school placement or for other educational purposes, or to determine if a learning disability exists.

RELATIONSHIP COUNSELING

Marriage or family counseling for the treatment of pre-marital, marital or family relationship dysfunction.

SERVICES FOR CERTAIN DIAGNOSES OR DISORDERS

Medical Supplies or services or charges for the diagnosis or treatment of learning disabilities, developmental speech delay, perceptual disorders, mental retardation or vocational rehabilitation.

SERVICES NOT LISTED AS COVERED BENEFITS

Medical Supplies or services or other items not specifically listed as a Benefit in Article III of this Plan of Benefits or on the Schedule of Benefits.

SERVICES PRIOR TO MEMBER EFFECTIVE DATE OR PLAN OF BENEFITS EFFECTIVE DATE

Any charges for Medical Supplies or services rendered to the Member prior to the Member's Effective Date, the Employer's Effective Date, or after the Member's coverage terminates, except as provided in Articles VI and X.

SERVICES RENDERED BY FAMILY

Any Medical Supplies or services rendered by a Member to himself or herself or rendered by a Member's immediate family (parent, child, spouse, brother, sister, grandparent or in-law).

SERVICES RESULTING FROM INTOXICATION OR DRUG USE

Any service (other than Substance Abuse Services), Medical Supplies, charges or losses resulting from a Member being intoxicated or under the influence of any drug or other substance; or, abusing alcohol, drugs, or other substance; or, taking some action the purpose of which is to create a euphoric state or alter consciousness unless taken on the advice of a Physician.

SEX CHANGE

Any Medical Supplies or services or charges incurred for consultation, therapy, surgery or any procedures related to changing a Member's sex.

SMOKING CESSATION TREATMENT

Unless such item has a dollar or percentage amount associated with it on the Schedule of Benefits, Medical Supplies, services or Prescription Drugs for smoking cessation.

TEMPOROMANDIBULAR JOINT (TMJ) DISORDER

Unless such item has a dollar or percentage amount associated with it on the Schedule of Benefits, any service for the treatment of dysfunctions or derangements of the temporomandibular joint, this exclusion also applies to orthognathic surgery for the treatment of dysfunctions or derangements of the temporomandibular joint.

TRAVEL

Travel, whether or not recommended by a Physician, unless directly related to human organ or tissue transplants specified in Article III and Pre-Authorized by the Corporation.

VIRTUAL OFFICE VISITS

Unless such item has a dollar or percentage amount associated with it on the Schedule of Benefits, charges incurred as a result of virtual office visits on the Internet, including charges for Prescription Drugs or Specialty Drugs. A virtual office visit on the Internet occurs when a Member was not physically seen or physically examined by an approved Internet Participating Provider.

VISION CARE

Unless such item has a dollar or percentage amount associated with it on the Schedule of Benefits, any Medical Supply or service rendered to a Member for vision care.

WORKERS' COMPENSATION

This policy does not provide benefits for diagnosis, treatment or other service for any injury or illness that is sustained by a Member that arises out of, in connection with, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required or is otherwise available for the Member. Benefits will not be provided under this Plan if coverage under the Workers' Compensation Act or similar law would have been available to the Member but the Member elects exemption from available Workers' Compensation coverage; waives entitlement to Workers' Compensation benefits for which he/she is eligible; failed to timely file a claim for Workers' Compensation benefits; or, the Member sought treatment for the injury or illness from a provider which is not authorized by the Member's employer.

If the Corporation pays benefits for an injury or illness and the Corporation determines the Member also received Workers' Compensation benefits by means of a settlement, judgment, or other payment for the same injury or illness, the Corporation shall have the right of recovery as outlined in Article IX of this Plan of Benefits.

ARTICLE V - COORDINATION OF BENEFITS

A. APPLICABILITY

Coordination of benefits is a limitation of Benefits designed to avoid the duplication of payments for Covered Expenses. Coordination of benefits under this Article V applies when a Member has health care coverage under one or more Plans that contain a coordination of benefits provision (or are required by law to contain a coordination of benefits provision). Additionally, special rules for the Coordination of Benefits with Medicare may also apply.

B. COORDINATION OF BENEFITS WITH AUTO INSURANCE

If the Member resides in a state where automobile no-fault, personal injury protection, or medical payments coverage is mandatory, or if the Member is involved in an accident in a state where such coverage is mandatory and the Member's automobile insurance carrier provides the state mandated coverage, the Member's automobile coverage is primary and the Plan takes a secondary status.

C. ORDER OF DETERMINATION RULES

When a claim is submitted under both this Plan of Benefits and another Plan, this Plan of Benefits is a Secondary Plan and the availability of Benefits is determined after benefits are determined under the other Plan unless:

1. The other Plan has rules coordinating its benefits with those of this Plan of Benefits; or,

2. There is a statutory requirement relating to the determination of benefits that is not pre-empted by ERISA; or,

3. Both the other Plan's rules and this Plan of Benefits' rules require that Benefits be determined before those of the other Plan.

D. RULES

This Plan of Benefits coordinates Benefits using the first of the following rules that apply:

1. Dependent Members.

   The Plan that covers an individual as an employee or retiree is the Primary Plan.

2. Dependent Child - Parents not Separated or Divorced.

   When this Plan of Benefits and another Plan cover the same Child as a Dependent then Benefits are determined in the following order:

   a. The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in the year.

b. If both parents have the same birthday, the benefits of the Plan that has covered a parent longer are determined before those of the other Plan.

c. If the other Plan does not have the rule described in (a) above, but instead has a rule based upon the gender of the parent; and if, as a result, the Plan and the Corporation do not agree on the order of benefits, the gender rule in the other Plan will apply.

3. Dependent Child - Separated or Divorced Parents.

If two (2) or more Plans cover a person as a Dependent Child of divorced, separated, or unmarried parents, benefits for the Child are determined in the following order:

a. First, the Plan of the parent with custody of the Child;

b. Second, the Plan of the spouse of the parent with the custody of the Child;

c. Third, the Plan of the parent not having custody of the Child.

d. If sections a-c above do not apply, the Plan of the spouse of the parent not having custody of the Child.

Notwithstanding the foregoing, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the Child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the Plan has actual knowledge of the existence of an applicable court decree.

If the specific terms of a court decree state that the parents shall share joint custody without stating that one of the parents is responsible for the health care expenses of the Child, the Plans covering the Child shall follow the order of determination rules outlined in section V (D) (2).

4. Active and Inactive Employees.

The benefits of a Plan that covers a person as an employee who is neither laid off nor retired, or as that employee's dependent, are determined before those of a Plan that covers that person as a laid off or retired employee, or as that employee's dependent. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of Covered Expenses, this rule does not apply.

5. Medicare.

This Plan of Benefits is a Secondary Plan with respect to Medicare benefits except where federal law mandates that this Plan of Benefits be the Primary Plan. Any claims where Medicare is primary must be filed by the Member after Medicare payment is made.

6. Longer and Shorter Length of Coverage.

If none of the above rules determines the order of benefits, the Plan that has covered the Member longer is the Primary Plan.

7. COBRA.

   COBRA allows coverage to begin or continue under certain circumstances if the Member already has or obtains coverage under a Group Health Plan. In these instances, two policies may cover the Member, and the Plan providing COBRA coverage will be the Secondary Plan.

E. EFFECT ON BENEFITS OF THIS PLAN OF BENEFITS

1. This Plan of Benefits as Primary Plan

   When this Plan of Benefits is the Primary Plan, the Benefits shall be determined without consideration of the benefits of any other Plan.

2. This Plan of Benefits as Secondary Plan

   When this Plan of Benefits is a Secondary Plan, the Benefits will be reduced when the sum of the following exceeds the Covered Expenses in a Benefit Year:

   a. The Covered Expenses in the absence of this coordination of benefits provision; plus

   b. The Covered Expenses that would be payable under the other Plan, in the absence of provisions with a purpose like that of this coordination of benefits provision, whether or not a claim is made.

   c. When the sum of these two (2) amounts exceeds the maximum amount payable for Covered Expenses in a Benefit Year, the Covered Expenses will be reduced so that they and the benefits payable under the other Plans do not total more than the Covered Expenses. When the Covered Expenses of this Plan of Benefits are reduced in this manner, each Benefit is reduced in proportion and then charged against any applicable limit of this Plan of Benefits.

3. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be a Covered Expense.

4. The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not a Covered Expense unless the Member's Admission in a private Hospital room is Medically Necessary. When benefits are reduced under a Primary Plan because a Member does not comply with the Primary Plan's requirements, the amount of such reduction in benefits will not be a Covered Expense.

F. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

The Corporation is entitled to such information as it deems reasonably necessary to apply these coordination of benefit provisions and the Member and the Employer must provide any such information as reasonably requested.

G. PAYMENT

A payment made under another Plan may include an amount that should have been paid under this Plan of Benefits. In such a case, the Corporation may pay that amount to the organization that made such payment. That amount will then be treated as though it had been paid under this Plan of Benefits. The term "payment " includes providing benefits in the form of services, in which case "payment " means the reasonable cash value of the benefits provided in the form of services.

H. RIGHT OF RECOVERY

If the amount of the payments made by the Corporation is more than the Corporation should have paid under this coordination of benefits section, the Corporation may recover the excess or overpayment from the Member on whose behalf it has made payments, from a Provider, from any group insurer, Plan, or any other person or organization contractually obligated to such Member with respect to such overpayments.

ARTICLE VI – TERMINATION OF THIS PLAN OF BENEFITS

A. GENERALLY

TERMINATION OF EMPLOYEE'S COVERAGE AND ALL OF SUCH EMPLOYEE'S DEPENDENTS' COVERAGE WILL OCCUR ON THE EARLIEST OF THE FOLLOWING CONDITIONS:

1. The date this Plan of Benefits is terminated pursuant to Article VI(B)-(I).

2. The date an Employee retires unless this Plan of Benefits covers such individual as a retiree.

3. The date an Employee ceases to be eligible for coverage as set forth in Article II.

4. The date an Employee is no longer Actively at Work, except that an Employee may be considered Actively at Work during a disability leave of absence for a period not to exceed ninety (90) days from the date the Employee is no longer Actively at Work or, for a qualified Employee (as qualified under the Family and Medical Leave Act of 1993), during any leave taken pursuant to the Family and Medical Leave Act of 1993.

5. In addition to terminating when an Employee's coverage terminates, a Dependent spouse's coverage terminates on the date of entry of an order or decree ending the marriage between the Dependent spouse and the Employee regardless of whether such order or decree is subject to appeal.

6. In addition to terminating when an Employee's coverage terminates, a Child's coverage terminates when that individual no longer meets the definition of a Child under this Plan of Benefits.

7. In addition to terminating when an Employee's coverage terminates, an Incapacitated Dependent's coverage terminates when that individual no longer meets the definition of an Incapacitated Dependent.

8. Death of the Employee.

B. TERMINATION FOR FAILURE TO PAY PREMIUMS

1. If the Premium remains unpaid after the Grace Period, this Plan of Benefits shall automatically terminate, without prior notice to the Employer, or to any Member, immediately after the last day of the Grace Period.

2. If a subgroup fails to pay the Premium after the Grace Period, this Plan of Benefits for that subgroup shall automatically terminate, without any prior notice to the Employer or Members, for nonpayment of Premium immediately after the last day of the Grace Period. Additionally, the Corporation retains the right to terminate this Plan of Benefits for the entire group in the event a subgroup fails to pay their portion of the Premium.

3. During the Grace Period the Corporation will pay Covered Expenses for Benefits (including Prescription Drugs) obtained by Members during the Grace Period.

4. In the event of termination for failure to pay Premiums, Premiums received by the Corporation after the Grace Period will not automatically reinstate this Plan of Benefits absent written agreement by the Corporation. The Corporation will refund the amount of any late Premium paid if this Plan of Benefits is not reinstated, except that portion relating to coverage provided prior to or during the Grace Period.

C. TERMINATION WHILE ON LEAVE

During an Employee's leave of absence that is taken pursuant to the Family and Medical Leave Act, the Employer must maintain the same health benefits as provided to Employees not on leave. The Employee must continue to pay his or her portion of the Premium and the Employer will continue to pay the same Premium the Employer would have paid had the Employee been Actively at Work. If Premiums are not paid by an Employee within thirty-one (31) days of the Premium due date, coverage ends as of the due date of that Premium contribution.

D. TERMINATION FOR LACK OF MEMBERSHIP

If there is no longer any Member who lives, resides or works in South Carolina or in an area for which the Corporation is authorized to do business, the Corporation may terminate this Plan of Benefits and coverage will terminate on the date given by the Corporation in written notice to the Employer.

E. UNIFORM TERMINATION OF COVERAGE

1. The Corporation may terminate coverage under this Plan of Benefits if:

   a. The Corporation ceases to offer coverage of the type of group health insurance coverage provided by this Plan of Benefits and provides notice to the Employer and Members at least ninety (90) days prior to the date of the discontinuation of such coverage; and

   b. The Corporation offers to each Employer provided coverage of this type in such market the option to purchase any other group health insurance currently being offered by the Corporation to a Group Health Plan in such market; and

   c. The Corporation acts uniformly without regard to the claims experience of the Employer or any Health Status-Related Factor relating to any Members or Employees or Dependents who may become eligible for such coverage.

2. If the Corporation elects to discontinue offering all group health insurance coverage in South Carolina, coverage under this Plan of Benefits may be discontinued by the Corporation only in accordance with applicable state law; and

3. The Corporation provides notice to the Department of Insurance and to affected Employer and Members of such discontinuation at least one hundred eighty (180) days prior to the date of the discontinuation of such coverage; and

4. All group health insurance coverage issued or delivered for issuance in South Carolina is discontinued and coverage under such health benefit coverage in such market is not renewed; and

5. In the case of a discontinuation in a market, the Corporation will not issue any group health insurance coverage in the market during the 5-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

F. NOTICE OF TERMINATION TO MEMBERS

Other than as expressly required by law, if this Plan of Benefits is terminated for any reason, the Employer is solely responsible for notifying all Members of such termination and notifying Members that coverage of Members under this Plan of Benefits will not continue beyond the termination date. The Employer agrees to indemnify and hold the Corporation harmless for all damages, claims, causes of action, penalties, fines, charges, costs and expenses (including a reasonable attorney's fee) arising out of or relating to the Employer's failure to notify Members of termination of this Plan of Benefits.

G. REINSTATEMENT

The Corporation in its sole discretion (and upon such terms and conditions as the Corporation may determine) may reinstate coverage under this Plan of Benefits that has been terminated for any reason. If a Member's coverage (and including coverage for the Member's Dependents) for Covered Expenses under this Plan of Benefits terminates while the Member is on leave pursuant to the Family and Medical Leave Act because the Member fails to pay such Member's portion of the Premium within the Grace Period, the Member's coverage will be reinstated without new Probationary Periods if the Member returns to work immediately after the leave period, re-enrolls, and within thirty-one (31) days following such return pays all such Employee's portion of the past due amount and then current Premium.

H. EXTENSION OF BENEFITS FOLLOWING TERMINATION

If this Plan of Benefits is terminated under this Article VI(H), or a Member participating in this Plan of Benefits is terminated, all rights to receive Covered Expenses for Benefits provided on or after the date of termination will automatically cease, except that a Member admitted to a Hospital or Skilled Nursing Facility or totally disabled on the date of such termination will be entitled to Covered Expenses for each day of that Admission or total disability, but will be limited to Benefits (including Prescription Drugs) directly related to the illness or injury causing the confinement or the total disability and will continue until the earlier of:

1. The date of recovery of the Member from the total disability; or,

2. A period of three hundred sixty five (365) days from the date of termination of this coverage, or,

3. The date on which the Covered Expenses to which the Member is entitled are exhausted; or,

4. The date the Member has full coverage for the disabling condition under another Group Health Plan with benefits that are similar to the Benefits and such Group Health Plan makes a reasonable provision for continuity of care for the disabling condition.

I. EMPLOYER IS AGENT OF MEMBERS

By accepting Benefits, a Member agrees that the Employer is the Member's agent for all purposes of notification of any notice under this Plan of Benefits. The Member further agrees that notifications received from, or given to, the Employer by the Corporation are notification to the Employees except for any notice required by state or federal law to be given to the Members by the Corporation.